Kyung Hee University Exchange Program

**Medical Assessment**

Please provide accurate information for the following questions.

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| **NAME OF STUDENT:** | | **SEX:**  Male  Female |
| **DATE OF BIRTH:** (YYYY/MM/DD) | **NATIONALITY:** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **QUESTION** | **YES** | **NO** | **EXPLAIN** |
| ① When and for what reason did he/she last consult a physician? (Please explain) |  | | |
| ② Has he/she had any serious ailment, injuries or diseases in the last five years? (If yes, please explain) |  |  |  |
| ③ Has he/she been hospitalized in the last two years?  (If yes, please explain) |  |  |
| ④ Has he/she ever been treated by a doctor for any mental, emotional, or anxiety disorder? (If yes, please explain and attach medical evaluation report.) |  |  |
| ⑤ Has he/she ever been addicted to any substance?  (If yes, please explain) |  |  |
| ⑥ Does he/she have any allergies? (If yes, please list them) |  |  |
| ⑦ Is he/she taking any prescribed medication?  (If yes, please explain) |  |  |
| ⑧ Is he/she on a special diet? (If yes, please explain in detail) |  |  |
| ⑨ Has he/she ever suffered from depression?  (If yes, please explain) |  |  |
| ⑩ Has he/she ever contracted Tuberculosis?  (If yes, please explain) |  |  |

**※ The answers must be completed by a doctor.**

**※ Tuberculosis(TB) test results MUST be submitted with this medical assessment form.**

**Click here for the Date**

**Date(YYYY/MM/DD) Signature and name of physician/doctor**